



Addendum to the Monthly HCTC Registration Form
Complete this form only if your qualified health plan is COBRA.

The American Recovery and Reinvestment Act of 2009 established a 65% employer-provided COBRA Health Insurance Continuation Premium Subsidy for employees who involuntarily lose their jobs. This new COBRA program is different from the Health Coverage Tax Credit (HCTC) Program. **If you elect to receive a COBRA Premium Subsidy from your former employer, you are not eligible to receive the HCTC during the same month.**

If your qualified health plan is COBRA, you need to sign and date this form to certify that upon enrolling in the monthly HCTC Program you will not receive an employer-provided COBRA subsidy and the HCTC during the same month.

For more information on the COBRA Premium Subsidy program, contact the Department of Labor toll-free at 1-866-444-3272 or visit www.dol.gov/COBRA. If you are unsure whether you receive a COBRA subsidy, contact your former employer.

Confirm that the following statement is true by checking the box.

- ☐ Upon enrolling in the monthly HCTC Program, I certify that I will not receive a COBRA subsidy and the HCTC during the same month. I understand that a knowingly and willfully false statement can result in my disqualification from the Monthly HCTC Program and I may have to repay the IRS any credit amount I receive.

Sign and date below to have your registration processed.

Signature

Full Name

Date

Return this form with your Monthly HCTC Registration Form.